R590. Insurance, Administration.
R590-175. Basic Health Care Plan Rule.
R590-175-3. General Requirements.

(1) Each insurer who is required to offer a health care plan under the open enrollment provisions of Chapter 30 shall file with the department at least one basic health care plan which is specified by the insurer as complying with the provisions of this rule and which must be offered for sale to anyone qualifying for open enrollment under Chapter 30.

(2) The basic health care plan shall not be designed or marketed in a manner that tends to discourage its purchase by anyone under the open enrollment provisions of Chapter 30.

(3) A plan having actuarial equivalence may be considered, at the sole discretion of the commissioner.

(4) Each insurer must use the language in this rule to present covered services, limitations and exclusions.

(5) A plan offered in compliance with the open enrollment provisions of Chapter 30 must contain at least the benefits set forth in the Basic Health Care Plan as adopted by the commissioner.

(6) The basic health care plan is to be offered as a package, in its entirety, and is mutually exclusive of and not comparable on a line by line basis to an insurer's other plans.

(7) If the basic health care plan is offered by a preferred provider organization, PPO, the benefit levels shown in the plan are for contracting providers; benefit levels for non-contracting providers' services may be reduced in accordance with Section 31A-22-617.

(8) Each insurer is to include its usual contracting provisions in its basic health care plan including submission of claims, coordination of benefits, eligibility and coverage termination, grievance procedures general terms and conditions, etc.

(9) Each insurer who is required to offer a group conversion plan under Subsection 31A-33-723 shall file with the department at least one basic health care plan that complies with the provisions of this rule and must be offered for sale to anyone qualifying for conversion.

(10) The form to follow for the Basic Health Care Plan is as follows:

TABLE
BASIC HEALTH CARE PLAN

1. MAXIMUM BENEFIT. The maximum benefit per person for the entire period for which this policy coverage is in effect shall be $1,000,000.

2. ANNUAL MAXIMUM BENEFIT. The maximum annual benefit per person shall not be less than $250,000[~~$300,000~~].

3. OUT OF POCKET MAXIMUM PER PERSON. The annual out of pocket maximum per person not to exceed[~~shall be~~] $5,000, including any deductibles, copayments or coinsurances in the plan, for family coverage, not to exceed three times the per person out-of-pocket maximum.

4. PREEXISTING CONDITION LIMITATION.

(a) Any preexisting condition limitation shall be in compliance with Utah Code Subsection 31A-22-605.1(4); and

(b) Any waiting period shall not exceed 12 months, or 18 months in the case of a late enrollees, with credit for prior coverage when applicable.

5. GENERAL COST-SHARING FOR MEDICAL BENEFITS.

[~~(a)~~]Cost-sharing shall be based on eligible expenses.[~~,~~]

[~~(b)~~]The cost-sharing features of the plan shall be the following:

(a)[~~(i)~~] Annual Deductible.

(i)[~~(A) The~~]A major medical deductible of[~~may~~] not [~~be~~]less than $1,500 per person, for family coverage not to exceed three times the per person deductible for major medical expenses; and

(ii) an ~~(B) An~~ annual deductible for prescription benefits [~~may~~]not to exceed $1000[~~be less than $500~~] per person, for family coverage not to exceed three times the per person deductible.

(b)[~~(ii)~~] Copayment and Coinsurance.

(i)(A) A copayment [~~is~~]of not less than $25 per visit for office visits, including preventive care services; and[~~.~~]

(B) A copayment [~~is~~]of not less than $150 per visit to the emergency room; or[~~.~~]

(ii) [~~(iii) Coinsurance. A~~ coinsurance of not[~~For all covered services other than prescriptions, the person shall pay not~~] less than 20% coinsurance per visit for office services[~~visits~~] and 20% per emergency room visits.

6. PREVENTIVE SERVICES. Preventive services covered under a managed care plan shall not be subject to the annual deductible. Covered preventive services shall consist of at least the following:

(a) childhood immunizations in accordance with guidelines as recommended by the Centers for Disease Control, as directed and modified from time to time;

(b) well-baby care through age five in accordance with guidelines recommended by the American Academy of Pediatrics, as directed and modified from time to time;

(c) for adults and adolescents, age, sex and risk appropriate preventive and screening services in accordance with Classification A guidelines recommended by the U.S. Preventive Services Task Force, as directed and modified from time to time.

7. COST SHARING FOR PRESCRIPTION DRUGS. Benefits for prescription drugs, other than self injectable drugs, except insulin, shall be subject to either:

(a) a copayment of not more than:

(i) the lesser of the cost of the prescription drug or $15 for the lowest level of cost for prescription[~~first tier of~~] drugs;

(ii) the lesser of the cost of the prescription drug or $25 for the second level of cost for prescription[~~or $30 for the middle tier of~~] drugs; and

(iii) the lesser of the cost of the prescription drug or $35 for the highest level of cost for prescription[~~or $60 for the highest tier of~~] drugs; or

(b) a coinsurance of not less than:

(i) the lesser of the cost of the prescription drug or 25% for the lowest level of cost for prescription[~~first tier drugs~~];

(ii) the lesser of the cost of the prescription drug or 40% for the second level of cost for prescription[~~middle tier~~] drugs; and

(iii) the lesser of the cost of the prescription drug or 60% for the highest level of cost for prescription[~~the highest tier of~~] drugs.

8. COST SHARING FOR MENTAL HEALTH BENEFITS AND/OR SUBSTANCE ABUSE SERVICES.

Benefits for mental health and substance abuse services shall provide:

(i) for individual policies:

(A) coinsurance of 50% of eligible expenses;

(B) inpatient services limited to 10 days annually per person; and

(C) benefits for outpatient services limited to 20 visits annually per person;

(ii) small employer group policies shall be subject to Sections 31A-22-625 and 31A-22-715; and

(iii) large employer group policies shall be subject to the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

[~~Benefits for mental health services will be provided only on conversion policies issued from group health plans offering mental health benefits and at the same level of the group policy.~~]

KEY: insurance
Date of Enactment or Last Substantive Amendment: [~~February 8, 2008~~]2009
Notice of Continuation: November 8, 2005
Authorizing, and Implemented or Interpreted Law: 31A-22-613.5